DOCUMENT RESUME

ED 424 963 PS 027 095

TITLE Diagnosis: Indicators of the Health and Safety of Young Tennesseans. A Tennessee KIDS COUNT Project Report.
INSTITUTION Tennessee State Commission on Children and Youth, Nashville.
SPONS AGENCY Annie E. Casey Foundation, Baltimore, MD.
PUB DATE 1992-11-00
NOTE 23p.
PUB TYPE Numerical/Quantitative Data (110) -- Reports - Descriptive (141)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Birth Weight; *Child Health; *Children; Counties; Demography; Health Insurance; Infant Mortality; Mortality Rate; *Poverty; Prenatal Care; *Social Indicators; State Surveys; Statistical Surveys; Tables (Data); Trend Analysis; *Well Being
IDENTIFIERS Child Mortality; *Indicators; *Tennessee

ABSTRACT

This Kids Count report examines the well being of Tennessee's children, focusing on their health and safety. The statistical portrait is based on 5 health and safety indicators of child well being: (1) adequate prenatal care; (2) low birthweight births; (3) infant mortality; (4) population under 21 years eligible for Medicaid; and (5) child deaths. The report's introductory section, "Prognosis," presents the 10 Tennessee counties ranking worst numerically and percentage-wise on births without adequate prenatal care, low birthweight births, and infant mortality. Following the introduction, the report presents both numerical and percentage data for each of the indicators by county and for the state as a whole. After the indicator information, the "Prescription" section presents recommendations by the Tennessee Commission on Children and Youth, including increasing public awareness of family planning programs, increasing access to health care for pregnant women, providing rehabilitation services for women who are substance abusers, providing parenting education for new parents, promoting children's access to adequate nutrition, and ensuring that all children are properly immunized. The report concludes with data sources and a list of members of the Tennessee Commission on Children and Youth and Kids Count advisory committees. (KB)

DIAGNOSIS

Indicators of the Health and Safety of Young Tennesseans

TENNESSEE kids count

1

A Tennessee KIDS COUNT Project Report

Prepared by The Tennessee Commission on Children and Youth
A KIDS COUNT Grantee

Tennessee Commission on Children and Youth
404 James Robertson Parkway, Suite 1510
Nashville, TN 37243-0800
(615) 741-2633 FAX: (615) 741-5956

November, 1992

Contents

This publication is funded by The Annie E. Casey Foundation

Tennessee Commission on Children and Youth authorization number 316004, November 1992, 3300 copies. This public document was promulgated at a cost of 50 cents per copy.

Prognosis

Too Many Children Unhealthy, Dying

Tennessee has a higher infant mortality rate than the United States as a whole and 23 other nations.

The U.S. and 28 other nations have lower percents of infants with low birth weight, and 16 nations have lower child death rates than Tennessee.

With a focus on early childhood health and safety indicators, this Tennessee KIDS COUNT/Tennessee Commission on Children and Youth report reveals that the prognosis of the health and safety of Tennessee infants and young children is often poor.

Adequate prenatal care, positive birth outcomes, and adequate nutrition and preventative health care in infancy and early childhood are essential for Tennessee children to have healthy lives.

The health indicators in *Diagnosis: Indicators of the Health and Safety of Young Tennesseans* - prenatal care; low-birth-weight births; infant mortality; routine health care as reflected in Medicaid eligibility and the use of Early Periodic Screening, Diagnosis and Treatment (EPSDT) services; and childhood death rates - provide a statistical prognosis of the health and safety of young Tennesseans.

These data are reported on residents of the state and counties, rather than where the incidents occurred.

Indicator data are reported in the actual numbers of incidents and in percentages or other rates of occurrence.

This report illustrates that focusing on the rates emphasizes the problems in poor, rural counties, while a focus on the actual numbers places emphasis on the most populous counties.

Percentages and Other Rates

Examination of how counties rank in percentage of births without adequate prenatal care, percentage of low-birth-weight babies and infant mortality rate shows that a county that has a high rate in one indicator will probably have high rates in one or more of the other two.

Seven counties are among the worst ten on two or more of these indicators. They are Grundy, Houston, Lake, Lewis, Smith, Stewart, and Trousdale counties. These seven counties are rural and poor, and have few or no physicians who specialize in obstetrics or family practitioners who provide obstetrical services.

Numbers

While the percentages and rates are worst in some rural counties, populous counties have much higher *total numbers* of births without adequate prenatal care, low-birth-weight babies, and infant deaths.

In total numbers, nine counties are among the worst in all three indicators: births without adequate prenatal care; low birth weight; and infant mortality. A tenth county is among the worst ten in births without adequate prenatal care and infant mortality. *(See chart, page 3.)*

The variations between urban and rural counties are significant in identifying strategies to improve the health of young Tennesseans.

Undeniably, the availability of health services in poor, rural areas needs to be improved. However, focusing additional resources on urban areas,

particularly Shelby County, can have the greatest impact on reducing the numbers of births without adequate prenatal care, low-birth-weight babies, and infant deaths.

In 1990, Shelby County - with its huge pockets of urban poverty - accounted for 24.9% of Tennessee births without adequate prenatal care; 27.6% of the low-birth-weight babies statewide; and 29.6% of the Tennessee infants who died before their first birthdays.

Many of Tennessee counties have infant mortality rates higher than some third world countries. (2)

Statewide, 46.1% of births without adequate prenatal care, 54.6% of low-birth-weight babies, and 51.6% of all infant mortality cases occurred in five counties.

While there have been notable improvements in some of these health indicators, particularly in the areas of low birth weight babies and infant mortality, there are still too many low-birth-weight babies and infant deaths.

The 770 babies who died in Tennessee in 1990 would have filled almost 39 kindergarten classes in 1995-96.

Adequate prenatal care must be followed by adequate health care and immunizations during early childhood. Immunizations prevent unnecessary diseases that could cause severe life-long disabling conditions and death. Early diagnosis of health problems can result in improved prognoses for patients.

Accidents are the leading cause of death for children ages 1-14, accounting for almost 50% of all deaths. Attention to safety conditions and precautions can prevent accidents and lessen their severity.

While *Diagnosis* focuses on health indicators that are more likely to affect poor Tennesseans, some of these problems could happen to anyone. No Tennessean is immune from having a low-birth-weight baby, from an infant dying before his or her first birthday, or from a child dying from an accident or disease.

It is incumbent upon all Tennesseans to assure the availability of resources to provide all Tennessee infants and children with a healthy start to a long and productive life.

No Tennessean is immune from having a low-birth-weight baby, from an infant dying before his or her first birthday, or from a child dying from an accident or disease.

The goal of *Diagnosis: Indicators of the Health and Safety of Young Tennesseans* is to provide Tennessee citizens and policy makers with information needed to ensure that women will have the opportunity to receive adequate prenatal care and that our children have the health care necessary to ensure that their futures are bright.

KIDS COUNT is a Tennessee Commission on Children and Youth project funded by The Annie E. Casey Foundation, the nation's largest philanthropy devoted exclusively to disadvantaged children. It was established by the founders of United Parcel Service to improve family and community environments that shape young people's health, development, education, opportunities and aspirations.

The Tennessee Commission on Children and Youth is an independent state agency that advocates for improvements in the quality of life for Tennessee children and families.

10 Counties Ranking Worst Numerically on Three Child-Health Indicators

Number of Births Without Adequate Prenatal Care	Number of Low-Birth-Weight Babies Born	Number of Infant Deaths
Shelby	Shelby	Shelby
Davidson	Davidson	Davidson
Hamilton	Knox	Hamilton
Knox	Hamilton	Knox
Montgomery	Montgomery	Montgomery
Sullivan	Rutherford	Madison
Rutherford	Sullivan	Sullivan
Madison	Madison	Greene
Sumner	Sumner	Rutherford
Greene	Wilson	Sumner

10 Counties With Worst Rates on Three Child-Health Indicators

Percent of Births Without Adequate Prenatal Care	Percent of Babies Born With Low-Birth-Weight	Infant Mortality Rate
Stewart	Trousdale	Trousdale
Grundy	Grainger	Johnson
Haywood	Smith	Lake
Montgomery	Lake	Unicoi
White	Shelby	Lewis
Houston	Stewart	Crockett
Sullivan	Lewis	Grundy
Hawkins	Grundy	Smith
Greene	Dyer	Dickson
Cumberland	Houston	Carroll

Prenatal Care

A Matter of Life or Death

Early and regular prenatal care is the best defense against low birth weight and infant mortality. There is no substitute for such care. A woman who fails to receive early prenatal care endangers her child's life and, perhaps her own. Ensuring access to prenatal care will reduce infant deaths during the first critical year of life. (1)

During this nine-month period, the child's needs are greater than at any other time for proper nourishment and suitable conditions. (2) Health and contentment during pregnancy depends largely on the proper guidance by a competent health care professional such as a physician, midwife, or specially trained nurse. Preconceptional care is now being given more attention so that the woman has an established relationship with a physician who knows her medical history.

After a pregnancy test has shown positive results, monthly prenatal care visits should begin during the first trimester (the first three months of the pregnancy). If a relationship with the physician has not already been established, a medical history will be taken at this time. The medical history is taken to determine whether there are any past illnesses or hereditary tendencies that might be intensified or aggravated by pregnancy. If there are, precautionary measures are instituted. Additional information on previous miscarriages, abortions, and the number of children the woman has are recorded. Detailed information on miscarriages is noted and. if necessary, investigated. (3)

Special care during pregnancy may be required depending on the expectant mother's medical history. Certain previous medical illnesses such as heart, liver, or kidney ailments may require special care. If the ailments have been serious, pregnancy may involve danger for both child and mother. Diseases such as tuberculosis and gonorrhea call for special vigilance. (4) Diabetes or a family history of diabetes demands additional attention.

Prenatal care includes:

- Blood, urine and other tests.
- Ongoing medical care such as blood pressure checks, weight measurement of the uterine (womb) growth, checks of the baby's heart beat and pelvic exams as needed.
- Prenatal education on pregnancy, labor, delivery, baby care, parenting and family planning.
- Answers to the questions of the pregnant woman.
- Information about other services that may be needed.
- Nutritional assessment and counseling. (5)

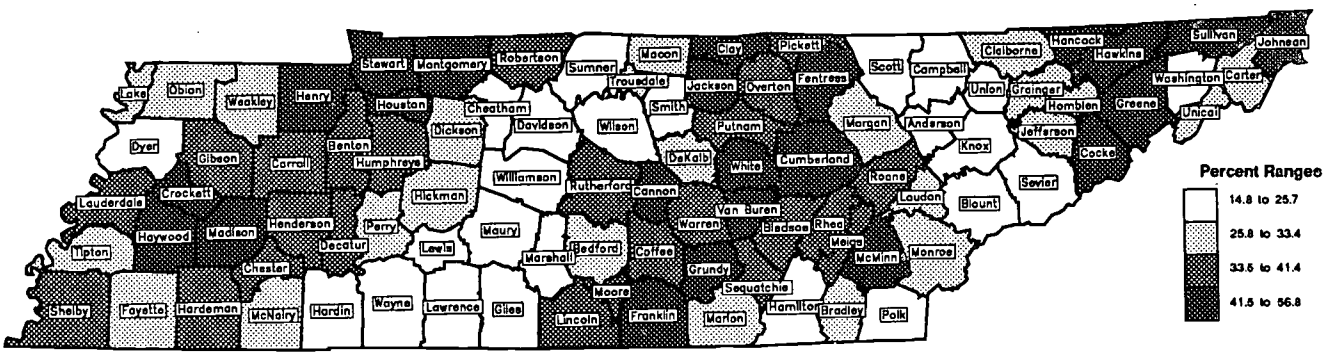
In Tennessee during 1990, only 67.7% of births had adequate prenatal care. (6) In line with the established national goals, the Tennessee Maternal and Child Health objective for the year 2000 is to increase to at least 90% the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy. To reach this goal, more Tennessee women should get adequate care during pregnancy.

There are two main reasons that so many women fail to receive adequate care during their pregnancies. The primary reason is that many cannot afford it. Even Medicaid eligibility does not ensure early prenatal care. A March 1991 survey of 57 obstetricians and gynecologists in Knoxville indicated only two of them would accept a woman on Medicaid. (7) In spite of this, Medicaid paid for almost 50% of the babies born in 1990, according to the Tennessee Department of Health.

The second reason that some women fail to receive adequate care is that many live in rural counties with serious shortages of obstetrical practitioners so they have limited access to proper care. (See map on Page 6.) In seven counties where 50.8% or less women received adequate care, full prenatal services are not available. (See Page 7.) These counties also lack physicians who specialize in obstetrics or in family practice and provide obstetrical service. There are only five counties that have perinatal centers. (See Page 7.)

Women who receive adequate prenatal care can prevent problem pregnancies which can result in a baby of low birth weight, birth defects, or most tragically of all, infant deaths. Prevention is the best and most cost-effective way to promote the health of our next generation (8) and prenatal care is one of the best forms of prevention.

Percent of Births Lacking Adequate Prenatal Care, 1990



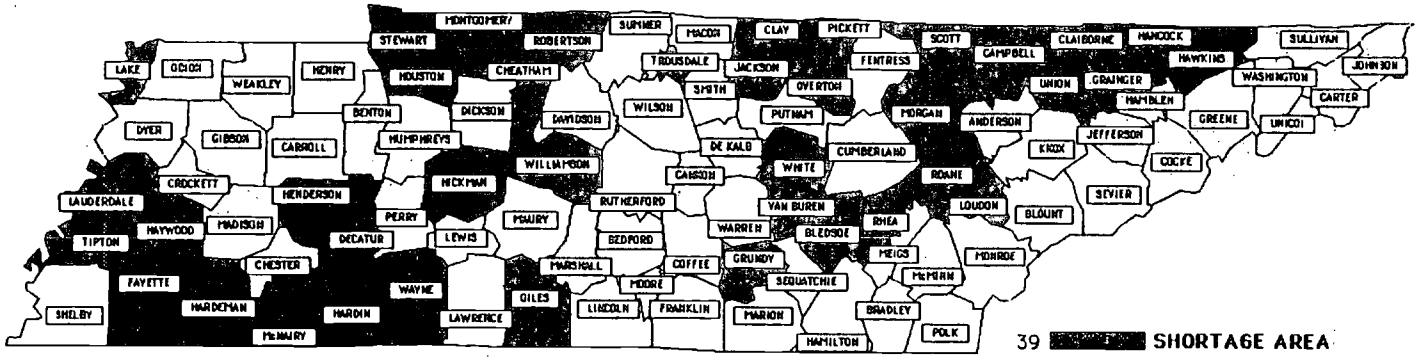
County	Prenatal Care	
	Adequate	Not Adequate
Anderson	74.3	25.7
Bedford	68.3	31.7
Benton	61.3	38.7
Bledsoe	65.0	34.9
Blount	75.3	24.7
Bradley	71.7	28.2
Campbell	78.3	21.7
Cannon	53.3	46.7
Carroll	64.4	35.6
Carter	69.7	30.2
Cheatham	75.2	24.7
Chester	62.3	37.7
Claiborne	72.6	27.3
Clay	56.7	43.3
Cocke	57.5	42.5
Coffee	65.6	34.4
Crockett	57.1	42.9
Cumberland	52.2	47.7
Davidson	78.4	21.7
Decatur	65.0	35.0
Dekalb	72.4	27.6
Dickson	68.4	31.6
Dyer	78.9	21.1
Fayette	67.6	32.4
Fentress	55.8	44.2
Franklin	56.6	43.5
Gibson	63.6	36.5
Giles	74.6	25.4
Grainger	69.5	30.5
Greene	52.2	47.8
Grundy	45.7	54.3
Hamblen	67.3	32.6
Hamilton	75.1	24.9

County	Prenatal Care	
	Adequate	Not Adequate
Hancock	57.6	42.3
Hardeman	58.7	41.4
Hardin	76.8	23.1
Hawkins	51.1	48.9
Haywood	47.5	52.6
Henderson	59.9	40.1
Henry	53.3	46.8
Hickman	69.2	30.8
Houston	50.7	49.3
Humphreys	64.0	36.1
Jackson	57.3	42.8
Jefferson	72.2	27.8
Johnson	55.1	44.9
Knox	76.9	23.1
Lake	66.7	33.3
Lauderdale	62.3	37.7
Lawrence	77.1	22.9
Lewis	77.2	22.8
Lincoln	64.0	36.0
Loudon	67.7	32.4
McMinn	58.4	41.6
McNairy	66.8	33.2
Macon	69.4	30.6
Madison	53.1	46.9
Marion	70.7	29.4
Marshall	74.9	25.1
Maury	74.4	25.6
Meigs	62.6	37.3
Monroe	66.6	33.4
Montgomery	48.2	51.9
Moore	59.6	40.4
Morgan	70.2	29.8
Obion	71.1	28.9

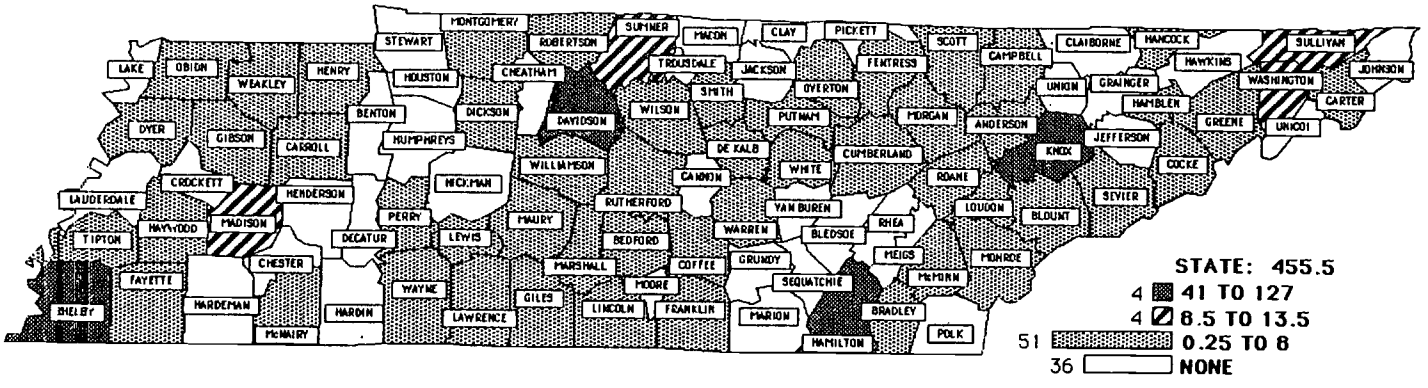
County	Prenatal Care	
	Adequate	Not Adequate
Overton	66.2	33.8
Perry	66.7	33.4
Pickett	62.7	37.3
Polk	75.7	24.3
Putnam	61.1	38.8
Rhea	65.5	34.4
Roane	64.7	35.3
Robertson	64.3	35.6
Rutherford	61.1	39.0
Scott	75.4	24.6
Sequatchie	64.2	35.8
Sevier	75.1	24.9
Shelby	62.0	38.0
Smith	74.7	25.3
Stewart	43.2	56.8
Sullivan	50.8	49.1
Sumner	77.3	22.8
Tipton	68.1	31.9
Trousdale	67.5	32.5
Unicoi	73.5	26.5
Union	77.5	22.4
Van Buren	54.7	45.3
Warren	61.9	38.1
Washington	74.6	25.5
Wayne	81.3	18.6
Weakley	67.5	32.5
White	49.8	50.2
Williamson	85.2	14.8
Wilson	76.5	23.5

Tennessee	**67.7**	**32.3**

PHYSICIAN SHORTAGE AREAS FOR PRIMARY CARE, NOVEMBER 1991



NUMBER OF FULL-TIME EQUIVALENT PHYSICIANS WITH A SPECIALTY OF OBSTETRICS, OBSTETRICS/GYNECOLOGY, OR FAMILY PRACTICE, WHO PROVIDE OBSTETRIC SERVICES, NOVEMBER 1991



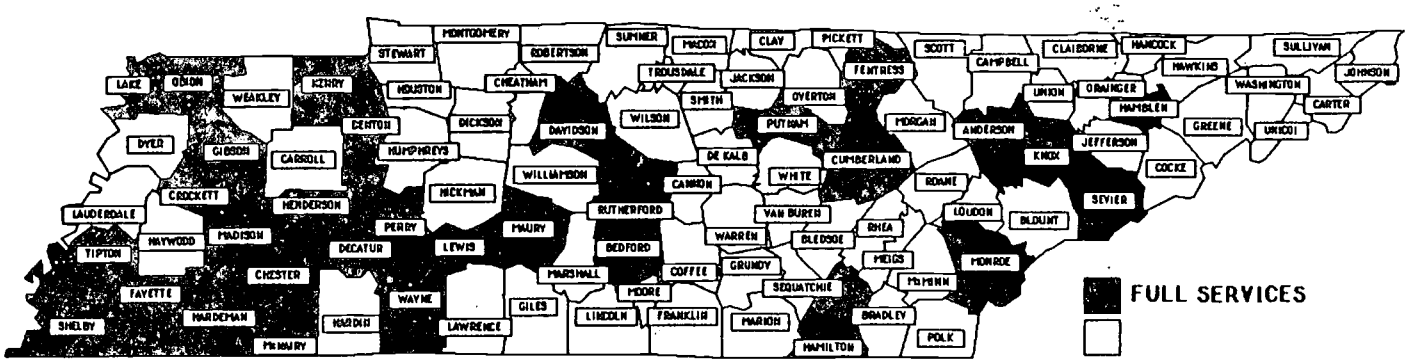
FULL PRENATAL SERVICES

In 31 selected counties needing such services, the Department of Health offers comprehensive prenatal services. These services consist of coordinated care by a physician or practitioner employed on-site by the Health Department. The Health Department staff provides prenatal care up to 36 weeks of pregnancy (unless an agreement with the private back-up physician differs or the pregnant woman develops serious problems), at which point a referral for private care is made.

The prenatal services offered by the county health department are the same as those offered in the private sector and comply with standards for care recommended by the American College of Obstetricians and Gynecologists. Patients are served regardless of ability to pay, and none are turned away.

Care coordination allows the patient to be able to receive other needed services such as WIC, and the patient is encouraged to return postpartum for family planning services.

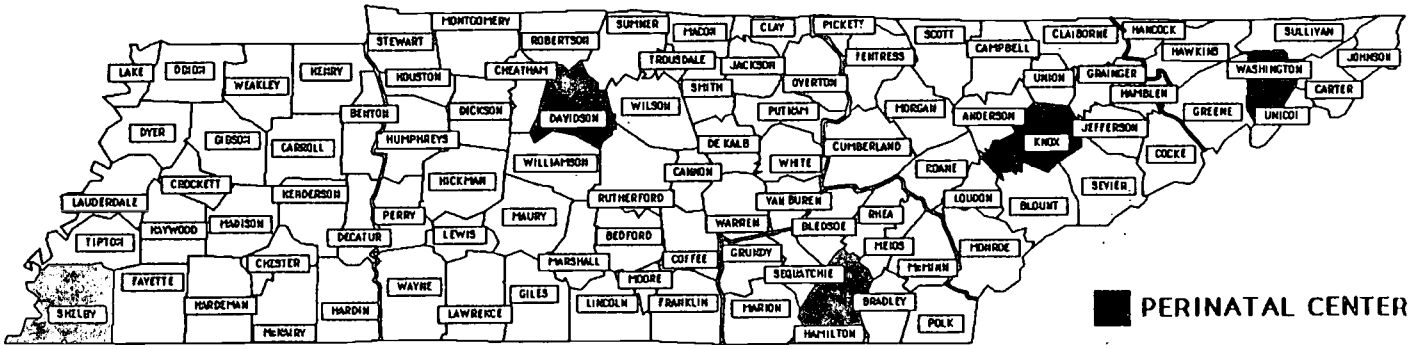
FULL PRENATAL SERVICES



PERINATAL CENTERS

There are five perinatal centers in Tennessee, each with a prescribed service area. These facilities are tertiary care hospitals located across the state that serve as regional centers under contract with the Tennessee Department of Health. Services provided by the regional centers include consultative emergency transport and medical, surgical, and ambulatory services to high-risk pregnant women and/or high-risk newborns, as well as regional inservices/outreach education and training for physicians, nurses, and other disciplines in accordance with Perinatal Regionalization Guidelines.

LOCATION OF PERINATAL CENTERS AND PERINATAL REGIONS



Low Birth Weight

A Major Factor in Infant Mortality

Too many babies in Tennessee are born of low birth weight. In 1990, 8.2% of our babies were born weighing less than 5.5 pounds. Compared to the national average of 7%, Tennessee ranked 44 among the states in 1989.

Improvement in this area is of paramount importance. Low birth weight is a major determinant of infant mortality, especially among those groups characterized by socioeconomic disadvantage. (1) These babies are 40 times more likely to die during the first month of life than normal weight infants. (2)

If these infants survive, they are more likely to have multiple health and developmental problems because of their fragile conditions. They are at risk of developing chronic respiratory problems such as asthma. (3) Babies of low birth weight may experience neurological problems associated with prematurity which result in seizures, epilepsy, hydrocephalus, cerebral palsy, or mental retardation. (4) They may also have hearing or vision problems which could be so severe that the result is blindness or deafness. Problems of the central nervous system may occur that could lead to meningitis or encephalitis. (5) These babies are also at risk for developing learning problems such as learning disabilities, hyperactivity, emotional problems and/or mental illness. (6)

Factors causing low birth weight are:

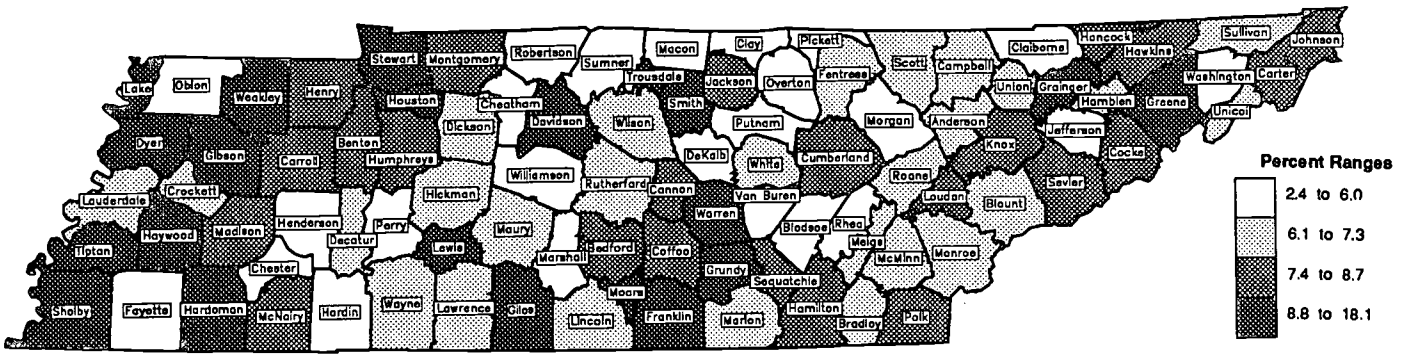
- Women who do not receive adequate prenatal care. They are three times more likely to deliver a low birth weight baby who needs extended hospital care than those receiving prenatal care. (7)
- Too many children are having children. In 1990, nearly 6,872 babies were born to teens aged 10 to 17 who run a high risk of having premature babies. (8)
- Women who smoke cigarettes, drink alcohol or abuse drugs.
- Pregnant women who are unmarried, lack health insurance, and lack access to a health care provider. (9)

The care for these babies during infancy through their childhood is extremely expensive. The lifetime costs of caring for a low-birth-weight baby can exceed $400,000. Every low-birth-weight birth that is averted saves the U.S. health care system between $14,000 and $30,000. (10) The most tragic aspect of this problem is that prenatal care, which may prevent low birth weight in the first place, can cost as little as $400. (11)

When compared to the statewide average of 8.2% low-weight births, it is important to note that of the 20 lowest ranking counties, 18 are rural and only Shelby (10.7%) and Davidson (9.0%) counties are urban. This indicates that even in urban areas where women have access to prenatal care, too many women have babies born of low birth weight.

Tennessee's objective for the year 2000 is to reduce low birth weight to no more than 7.1% of live births. Lowering the state average of 8.2% to meet this goal will require not only ensuring access to prenatal care for all pregnant women, but also targeting programs for poor women in urban areas who are at risk of having babies of low birth weight.

Percent of Low Birth Weight Babies*, 1990



County	Low Birth Weight Babies	
	Number	Percent
Anderson	59	6.8
Bedford	33	7.5
Benton	15	8.3
Bledsoe	3	2.4
Blount	72	6.3
Bradley	69	6.4
Campbell	31	6.7
Cannon	13	8.7
Carroll	27	7.4
Carter	48	8.1
Cheatham	25	6.0
Chester	5	3.4
Claiborne	15	4.3
Clay	3	3.3
Cocke	35	8.6
Coffee	50	7.6
Crockett	11	6.3
Cumberland	37	8.7
Davidson	787	9.0
Decatur	9	7.3
Dekalb	10	5.7
Dickson	37	6.5
Dyer	53	9.6
Fayette	20	5.3
Fentress	11	6.4
Franklin	38	9.1
Gibson	63	9.1
Giles	35	9.3
Grainger	31	14.8
Greene	59	8.8
Grundy	18	9.8
Hamblen	49	6.6
Hamilton	347	7.9

County	Low Birth Weight Babies	
	Number	Percent
Hancock	7	8.2
Hardeman	35	9.2
Hardin	18	5.6
Hawkins	46	8.3
Haywood	30	9.5
Henderson	13	4.6
Henry	29	8.6
Hickman	13	6.6
Houston	7	9.6
Humphreys	16	7.6
Jackson	9	7.7
Jefferson	23	5.7
Johnson	12	8.7
Knox	377	8.0
Lake	9	11.1
Lauderdale	27	7.1
Lawrence	37	6.2
Lewis	13	10.2
Lincoln	30	7.2
Loudon	33	7.7
McMinn	34	6.3
McNairy	23	8.1
Macon	12	5.5
Madison	96	7.6
Marion	24	7.2
Marshall	18	6.0
Maury	57	6.8
Meigs	7	6.5
Monroe	29	6.5
Montgomery	150	7.4
Moore	5	8.8
Morgan	12	5.3
Obion	26	6.0

County	Low Birth Weight Babies	
	Number	Percent
Overton	11	5.0
Perry	3	3.6
Pickett	2	3.9
Polk	13	7.7
Putnam	40	5.5
Rhea	20	5.6
Roane	37	7.3
Robertson	38	5.8
Rutherford	144	7.2
Scott	20	6.8
Sequatchie	10	7.5
Sevier	62	8.4
Shelby	1,700	10.7
Smith	23	11.6
Stewart	13	10.4
Sullivan	123	6.8
Sumner	86	5.9
Tipton	65	9.6
Trousdale	15	18.1
Unicoi	11	6.6
Union	13	7.0
Van Buren	3	5.7
Warren	41	8.8
Washington	64	5.4
Wayne	14	7.3
Weakley	36	9.1
White	20	7.3
Williamson	65	5.8
Wilson	73	7.2

Tennessee	**6,160**	**8.2**
U.S.A.*		**7.0**

* Low Birth Weight: A live birth weighing less than 5.5 pounds.
U.S. rate is for 1989.

Infant Mortality

Many Babies Need Not Die

The tragedy of 770 babies dying before their first birthday in Tennessee during 1990 is that at least half of deaths were preventable because many babies who die are of low birth weight. (1) Many of these births resulted from poor prenatal care which led to low birth weight. "Front-end maternity and early infant care are matters of life or death." (2)

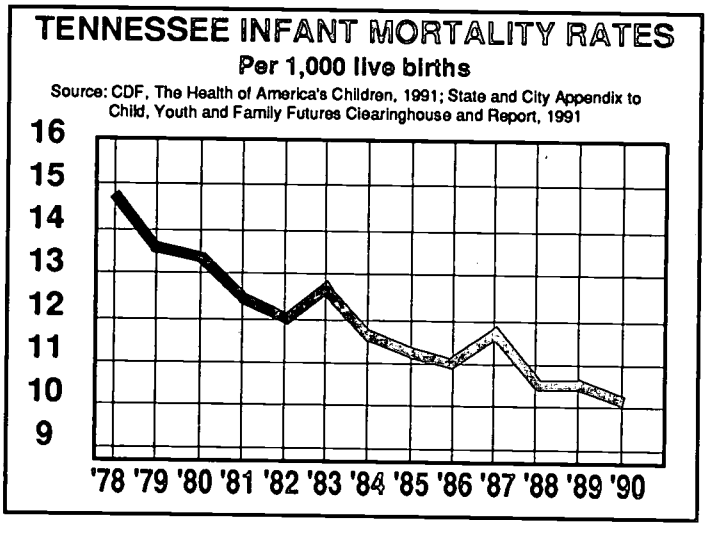
Many factors influence infant mortality rates. Some of them are:

- lack of prenatal care
- multiple births
- birth weight
- gestational age
- age of mother
- prior pregnancy outcome
- socioeconomic status
- maternal smoking
- race. (3)

For African-American infants, the story is most tragic. African-American infants "born to college-educated parents are almost twice as likely to die before their first birthday as white infants, even after such variables as the mother's age, marital status, amount of prenatal care and number of previous deliveries are taken into account." (4)

According to a pediatrician at the Harvard Medical School, "probably the most important thing is to realize that elevated black infant mortality rates are a legacy of poor women's health." (5) A researcher at Harvard Medical School has found that African-American women have "higher rates of infection, bleeding and pregnancy-induced hypertension, suggesting that there is probably no single cause for the greater rate of complication in black births." (6)

Tennessee's health objective is to reduce the infant mortality rate by the year 2000 to no more than 8 per 1,000 live births. This objective is in line with national goals for infant mortality. Tennessee's rate - 10.3 - leaves much room for improvement. To prevent babies from dying before they are one year old, it is imperative for pregnant women to seek early prenatal care. Because Tennessee's African-American population is large, it is also essential to target programs for African-American women of childbearing years to improve their health care.

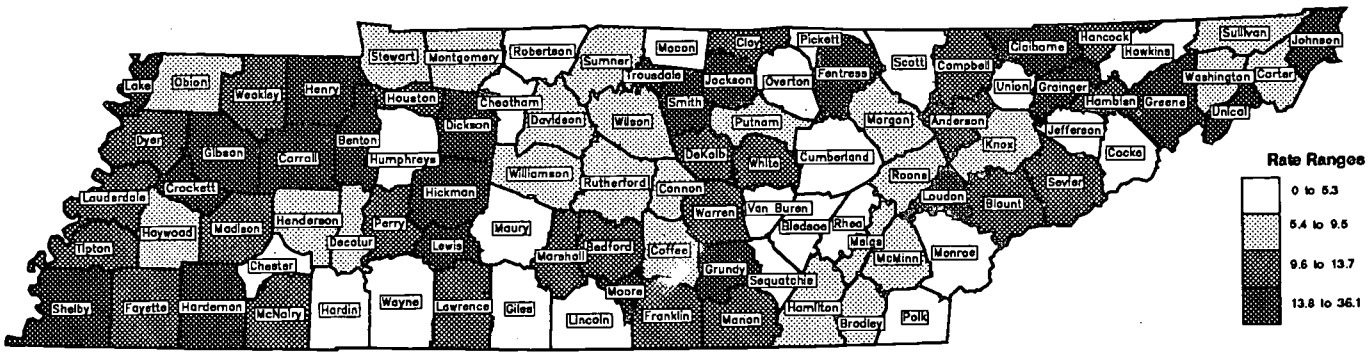


Tennessee Infant Mortality Rate (Per 1,000 live Births) By Leading Causes, 1990

Causes	Number	Rate
Birth Defects	174	2.3
Sudden Infant Death Syndrome	112	1.5
Short Gestation and Low Birth Weight	86	1.1
Respiratory Distress Syndrome	50	0.7
Infections Specific to Perinatal Period	25	0.3

Source: Tennessee's Health: Picture of the Present Part Two, 1992

Infant Mortality* Rate (Per 1,000 Live Births), 1990



County	Infant Mortality	
	Number	Rate
Anderson	9	10.4
Bedford	5	11.4
Benton	3	16.6
Bledsoe	0	0.0
Blount	11	9.6
Bradley	8	7.4
Campbell	6	12.9
Cannon	1	6.7
Carroll	7	19.2
Carter	4	6.8
Cheatham	1	2.4
Chester	0	0.0
Claiborne	6	17.3
Clay	1	11.1
Cocke	2	4.9
Coffee	6	9.1
Crockett	4	22.9
Cumberland	2	4.7
Davidson	83	9.5
Decatur	1	8.1
Dekalb	2	11.5
Dickson	11	19.2
Dyer	7	12.7
Fayette	4	10.7
Fentress	3	17.4
Franklin	5	11.9
Gibson	10	14.5
Giles	1	2.6
Grainger	3	14.3
Greene	12	17.8
Grundy	4	21.7
Hamblen	10	13.5
Hamilton	35	8.0

County	Infant Mortality	
	Number	Rate
Hancock	1	11.8
Hardeman	7	18.4
Hardin	1	3.1
Hawkins	1	1.8
Haywood	2	6.3
Henderson	2	7.1
Henry	5	14.8
Hickman	3	15.2
Houston	1	13.7
Humphreys	1	4.7
Jackson	2	17.1
Jefferson	2	5.0
Johnson	4	29.0
Knox	33	7.0
Lake	2	24.7
Lauderdale	5	13.2
Lawrence	7	11.7
Lewis	3	23.6
Lincoln	2	4.8
Loudon	7	16.4
McMinn	3	5.6
McNairy	3	10.6
Macon	0	0.0
Madison	17	13.4
Marion	4	12.0
Marshall	4	13.4
Maury	4	4.7
Meigs	1	9.3
Monroe	0	0.0
Montgomery	18	8.9
Moore	1	17.5
Morgan	2	8.8
Obion	4	9.2

County	Infant Mortality	
	Number	Rate
Overton	1	4.6
Perry	1	11.9
Pickett	0	0.0
Polk	0	0.0
Putnam	5	6.8
Rhea	0	0.0
Roane	4	7.9
Robertson	2	3.0
Rutherford	11	5.5
Scott	0	0.0
Sequatchie	0	0.0
Sevier	10	13.6
Shelby	228	14.4
Smith	4	20.2
Stewart	1	8.0
Sullivan	15	8.3
Sumner	11	7.5
Tipton	9	13.2
Trousdale	3	36.1
Unicoi	4	24.1
Union	1	5.3
Van Buren	0	0.0
Warren	5	10.8
Washington	9	7.5
Wayne	1	5.2
Weakley	5	12.7
White	3	10.9
Williamson	9	8.0
Wilson	9	8.9

Tennessee	**770**	**10.3**
U.S.A.*		**9.8**

* Infant mortality is defined as the death of a live-born infant under one year of age. U.S. rate is for 1989.

Health Care

Many Poor Children Not Treated

Routine well-baby and healthy-child medical check-ups are important tools for monitoring normal growth and development and for early identification of potential disease or problems. A part of preventive health treatment is providing immunizations on a recommended schedule. Immunizations are essential to avoid preventable diseases that cause life-long disabilities and even death.

Eligibility for Medicaid is an important means of providing access to and payment for health care for more than 400,000 poor Tennessee children - more than one out of every four children in the state. (1) The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program is the federally mandated service for providing medical care for indigent children who are Medicaid recipients.

Medicaid reforms included in the Omnibus Budget Reconciliation Act of 1989 expanded Medicaid coverage and strengthened the EPSDT program by:

- Mandating that states extend Medicaid coverage to all children under age 6, with family incomes below 133 percent of the federal poverty level;
- Requiring state EPSDT programs to cover a reasonable schedule of both periodic health and developmental, vision, hearing and dental exams, as well as interperiodic exams whenever a health, developmental or educational professional has reason to suspect that a child has a new (or worsening) problem; and
- Requiring states to cover virtually any medically necessary care recognized under federal law for children whose periodic or interperiodic screenings disclose a health problem, even if such services otherwise are not covered under the state's Medicaid plan. (2)

It is significant that the EPSDT program not only requires "screening", but also mandates "treatment". Medicaid reimbursement for treatment needs identified in the EPSDT process is significantly more comprehensive than routine Medicaid coverage.

Unfortunately, thousands of Tennessee children who are eligible to receive EPSDT services are never screened and, consequently, never treated.

The percent of eligible children who are screened diminishes significantly as they get older. The chart below reflects the percentage of EPSDT eligible children who received screenings by various age groups. (3)

Tennessee has renamed its EPSDT program "Check-Up for Children and Teens" (CUFCAT). Advocates can only hope that this emphasis on "check-up" in the new title is not intended to minimize the importance of treatment, particularly since so few eligible children even receive screening services.

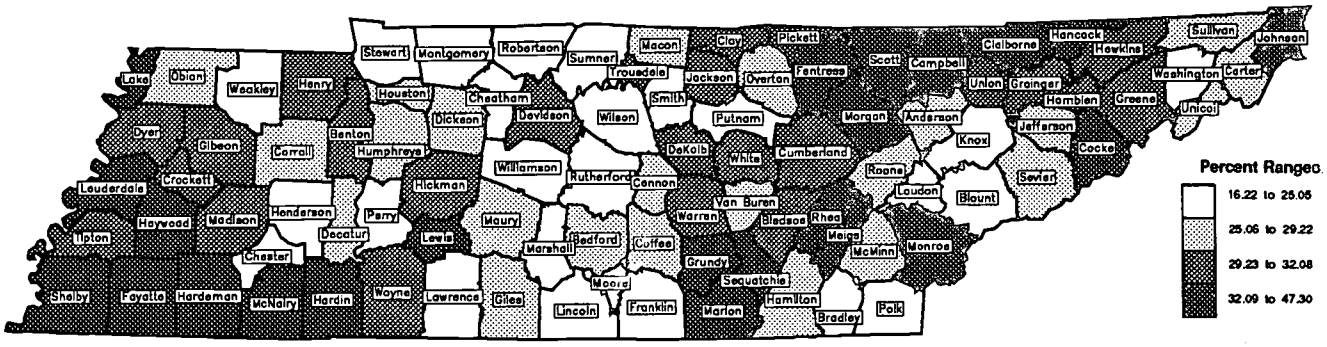
Improved outreach should assist in expanding the number of eligible children receiving EPSDT screening services, as well as needed follow-up treatment. Provision of screening and early intervention services is an important strategy for improving health conditions for many of Tennessee's most disadvantaged children.

EPSDT SCREENING PARTICIPATION
Oct. 1, 1990 - Sep. 30, 1991
Based on screening participation among those who have qualified, *not* all who may qualify.
Source: Department of Health and Environment - Bureau of Medicaid Statistics

CLIENT AGE	NUMBER EPSDT ELIGIBLE	NUMBER ELIGIBLES SCREENED	PERCENT SCREENED
Less than 1	36,017	34,656	96
1 to 5	169,644	46,196	27
6 to 14	135,587	14,580	11
15 to 20	85,672	4,111	5
All Ages	426,920	99,543	23

14

Percent of Population Under 21 Years* Eligible for Medicaid, 1991-1992



County	Medicaid Eligible	
	Number	Percent
Anderson	5,163	27.2
Bedford	2,326	25.7
Benton	1,200	30.9
Bledsoe	887	31.8
Blount	5,611	23.9
Bradley	5,157	23.2
Campbell	4,594	43.3
Cannon	858	28.1
Carroll	2,237	28.8
Carter	3,811	27.1
Cheatham	1,831	21.1
Chester	1,022	25.0
Claiborne	2,804	35.1
Clay	627	31.9
Cocke	3,350	40.2
Coffee	3,423	28.5
Crockett	1,179	31.3
Cumberland	2,915	30.5
Davidson	44,624	31.4
Decatur	823	29.2
Dekalb	1,208	29.9
Dickson	3,026	27.2
Dyer	3,071	29.3
Fayette	2,881	33.1
Fentress	1,860	41.2
Franklin	2,375	22.7
Gibson	3,915	30.1
Giles	1,934	25.1
Grainger	1,579	31.6
Greene	4,786	31.3
Grundy	1,774	40.6
Hamblen	4,302	29.7
Hamilton	23,469	28.6

County	Medicaid Eligible	
	Number	Percent
Hancock	881	44.4
Hardeman	3,055	40.1
Hardin	2,566	38.8
Hawkins	3,686	29.3
Haywood	2,454	38.0
Henderson	1,545	24.4
Henry	2,220	29.9
Hickman	1,446	30.7
Houston	561	28.2
Humphreys	1,164	25.3
Jackson	749	30.3
Jefferson	2,466	26.1
Johnson	1,594	42.3
Knox	22,741	24.1
Lake	864	45.6
Lauderdale	2,831	38.2
Lawrence	2,678	24.9
Lewis	1,040	36.1
Lincoln	1,890	23.1
Loudon	1,932	22.5
McMinn	3,596	29.2
McNairy	2,118	33.4
Macon	1,223	25.9
Madison	7,483	30.5
Marion	2,620	34.3
Marshall	1,341	21.1
Maury	4,446	26.9
Meigs	795	33.4
Monroe	3,316	35.3
Montgomery	6,716	20.4
Moore	289	20.5
Morgan	1,780	33.9
Obion	2,683	29.0

County	Medicaid Eligible	
	Number	Percent
Overton	1,424	28.5
Perry	473	25.1
Pickett	397	31.0
Polk	916	23.4
Putnam	3,313	21.4
Rhea	2,733	36.8
Roane	3,382	25.7
Robertson	2,850	21.9
Rutherford	6,397	16.2
Scott	2,937	47.3
Sequatchie	948	34.6
Sevier	3,998	27.8
Shelby	93,203	34.7
Smith	1,016	25.0
Stewart	592	24.0
Sullivan	9,682	25.2
Sumner	6,033	18.4
Tipton	3,989	30.5
Trousdale	505	30.2
Unicoi	1,113	25.9
Union	1,330	31.0
Van Buren	416	27.7
Warren	3,025	31.1
Washington	6,365	24.9
Wayne	1,343	32.1
Weakley	1,775	18.1
White	1,673	29.8
Williamson	2,929	11.1
Wilson	3,938	18.5

Tennessee	416,086	28.6

* The population under 21 years old is from the tables provided by the Center for Business and Economic Research, College of Business Administration, The University of Tennessee, Knoxville, 1992.

Child Deaths

Most Child Deaths Preventable

The tragedy of child death in Tennessee is that the leading cause of death of Tennessee's children is largely and relatively easy to prevent.

The primary killer of Tennessee's children ages 1 to 14 is accidents. As the chart below shows, nearly half of all child deaths are caused by accidents. And nearly half of all accidental child deaths are caused by motor vehicle accidents.

Preventing non-vehicular child deaths is not entirely up to government - although government can help.

Young children - who are naturally curious and completely unaware of their own mortality - must be watched and their surroundings must be as childproofed as possible.

As the Tennessee Department of Human Services personal safety curriculum says, "Young children ... cannot protect themselves. This is the responsibility of trusted, caring adults; parents; other family members; teachers and caregivers." (1)

"But," the same publication says, "young children can learn to identify dangers and problem situations; they can begin to learn and follow basic safety rules..."

The DHS child safety curriculum or a similar curriculum must, under state law, be taught in all licensed child care centers and pre-school centers.

Parents whose children are taught the required safety curriculum can reinforce its lessons and parents whose children are not taught the curriculum can take responsibility for teaching their children to avoid accidents.

Another way parents can greatly increase their children's safety is to use smoke alarms. They are relatively inexpensive and many fire departments will give them to citizens who cannot afford them.

Regarding motor vehicle accidents, the best prevention of death is the use of child restraints and safety belts. "A Vanderbilt University study found that restrained children are 11 times more likely to survive a traffic crash than those who are not in a safety seat," said state Safety Commissioner Robert Lawson. In 1990, compliance with Tennessee's child restraint law was estimated to be about 48 percent, Lawson said.

While enforcement is a useful tool in encouraging child restraint use - the Tennessee Highway Patrol handed out more than 8,000 tickets for violating the child restraint law in 1991 - the state Department of Safety also tries educating the public of the danger of not restraining children in moving vehicles.

National Child Passenger Safety Awareness Week, the second full week in February, provides the state safety department, child advocates and all citizens concerned about child deaths an opportunity to focus education efforts.

Safety education is generally not difficult to obtain. Free or inexpensive training is available for other activities that may be dangerous for children such as swimming lessons, gun safety courses and boating safety courses.

Before safety education is obtained, however, some people must become convinced of the need. It is hoped this report will help.

While accidents account for the majority of child deaths in Tennessee, other causes cannot be ignored. As the chart below shows, cancer is the second biggest killer of children. While the causes of some cancers are not yet known, we can work to reduce environmental causes such as air and water pollution.

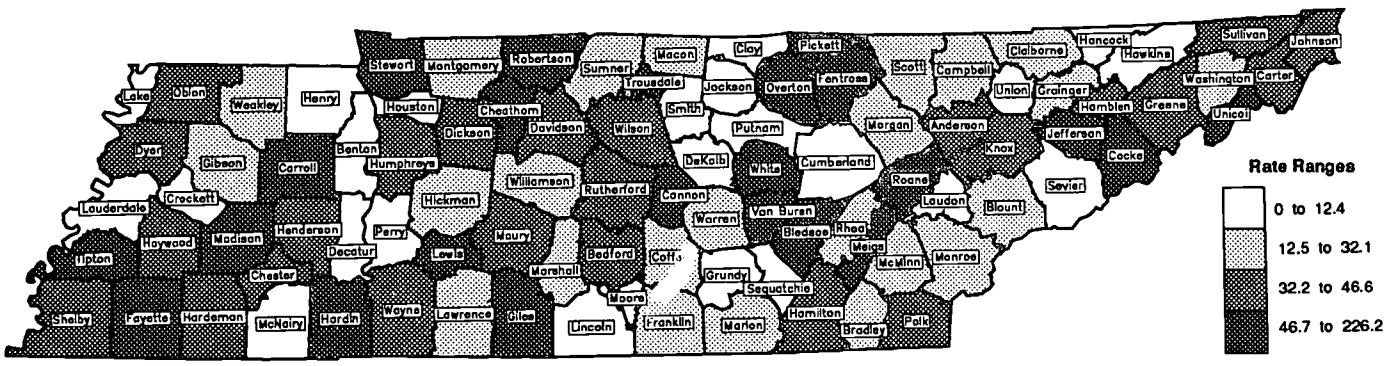
EDITOR'S NOTE: An examination of county child death rates shows that sparsely populated counties generally have either remarkably high or remarkably low rates compared to urban counties and to the state's rate. Pickett County, for example, has a child death rate of 226.2 per 100,000. Unicoi County's rate is 110.1. However, in 1990, two children died in Pickett County, and three children died in Unicoi County. Because of their low populations, some counties show an extremely high rate even though very few children died. Conversely, some similarly sparsely populated counties had rates of zero. One auto accident in which two or three children are killed could skyrocket the child death rate in a sparsely populated county from zero one year to 100 or 200 per 100,000 the next year.

Child Death Rate Per 100,000 by Leading Causes, 1990

Source: Tennessee's Health: Picture of the Present Part Two, 1992

	Children Ages 1-4		Children Ages 5-14	
Causes	Rate	Number Deaths	Rate	Number Deaths
Accidents	26.2	70	13.0	88
Motor Vehicle Accidents (Included in 'Accidents,' Above)	10.9	29	6.8	46
Birth Defects	5.2	14	0.9	6
Heart Disease	3.4	9	0.6	4
Cancer	3.0	8	3.3	22
2 or More Causes	2.6	7	NA	NA
Suicide	0	0	1.3	9
Homicide (Reported)	2.6	7	1.3	9

Child Death Rate Per 100,000 Children (Ages 1-14), 1990



County	Child Deaths	
	Number	Rate
Anderson	5	39.2
Bedford	2	33.0
Benton	0	0.0
Bledsoe	1	56.9
Blount	3	19.7
Bradley	3	21.2
Campbell	1	14.6
Cannon	2	97.0
Carroll	3	58.5
Carter	3	34.4
Cheatham	4	66.7
Chester	1	42.4
Claiborne	1	19.6
Clay	0	0.0
Cocke	3	56.3
Coffee	2	24.4
Crockett	0	0.0
Cumberland	0	0.0
Davidson	40	43.5
Decatur	0	0.0
Dekalb	0	0.0
Dickson	3	40.0
Dyer	3	43.3
Fayette	3	50.3
Fentress	2	68.4
Franklin	2	30.5
Gibson	2	23.1
Giles	4	80.2
Grainger	1	31.2
Greene	4	40.9
Grundy	0	0.0
Hamblen	3	32.6
Hamilton	22	40.9

County	Child Deaths	
	Number	Rate
Hancock	0	0.0
Hardeman	2	38.1
Hardin	3	69.1
Hawkins	1	12.4
Haywood	2	44.7
Henderson	2	46.6
Henry	0	0.0
Hickman	1	32.1
Houston	0	0.0
Humphreys	1	32.5
Jackson	0	0.0
Jefferson	3	55.2
Johnson	1	41.5
Knox	20	33.8
Lake	0	0.0
Lauderdale	0	0.0
Lawrence	1	13.9
Lewis	2	103.2
Lincoln	0	0.0
Loudon	0	0.0
McMinn	2	25.0
McNairy	0	0.0
Macon	1	31.7
Madison	8	49.5
Marion	1	19.9
Marshall	1	23.6
Maury	4	35.1
Meigs	1	64.6
Monroe	1	16.9
Montgomery	3	14.2
Moore	0	0.0
Morgan	1	29.6
Obion	2	33.6

County	Child Deaths	
	Number	Rate
Overton	2	61.4
Perry	0	0.0
Pickett	2	226.2
Polk	1	41.1
Putnam	1	11.4
Rhea	1	21.2
Roane	4	46.7
Robertson	5	55.5
Rutherford	10	39.7
Scott	1	23.9
Sequatchie	0	0.0
Sevier	1	10.6
Shelby	76	42.4
Smith	0	0.0
Stewart	1	61.3
Sullivan	8	32.6
Sumner	7	31.6
Tipton	5	54.6
Trousdale	1	88.4
Unicoi	3	110.1
Union	0	0.0
Van Buren	1	99.1
Warren	1	15.4
Washington	2	12.8
Wayne	1	36.5
Weakley	1	18.1
White	2	53.9
Williamson	4	21.3
Wilson	5	34.0
Tennessee	**333**	**35.0**
U.S.A.*		**32.4**

Note: The population ages 1-14 is calculated from the tables provided by the Center for Business and Economic Research, College of Business Administration, The University of Tennessee, Knoxville, 1992.
* U.S. rate is for 1989.

TCCY Offers Workable Solutions

Prescription

The information provided by this Tennessee KIDS COUNT/Tennessee Commission on Children and Youth report is a tool which, like a thermometer, can take the temperature of health indicators for early childhood in Tennessee, but cannot provide a cure for the fever.

Although the prognosis for the Health and Safety of Tennessee's young children is often poor, there are solutions - prescriptions of sorts.

As a result of inadequate education and awareness, many women in Tennessee go without necessary prenatal care. Many pregnant women and children who are not covered by private insurance or Medicaid have inadequate access to quality health care. As a result of their inability to pay and their fear of being denied services, they frequently go without routine prenatal care and other needed care until their conditions deteriorate into costly medical emergencies. Their health care is sporadic, uncertain and often crisis-driven. The effect of this circumstance on pregnant women can be damaging for the mother and the fetus.

Early and on-going prenatal care and programs have been shown to be efficient and cost-effective measures to improve the health of mothers and infants. Early and appropriate prenatal care provides the greatest insurance for healthy pregnancy outcomes. Access to ongoing medical care on a periodic schedule is essential for healthy development of children. It ensures an appropriate immunization schedule for children and periodic medical checkups for health maintenance, thus reducing acute medical conditions.

Accident-reduction efforts would further reduce unnecessary deaths and disabilities for Tennessee children.

The Tennessee Commission on Children and Youth recommends the following:

• Increase public awareness programs that stress the need for family planning to avoid unwanted pregnancies and early prenatal care when pregnant.

• Increase and ensure access to comprehensive prenatal, obstetrical and postpartum health care for all pregnant women, especially teens and low-income women.

• Increase access to health care and improve the availability of obstetricians, pediatricians, family practitioners, school nurses, and other health care providers in underserved areas using creative strategies such as physician recruitment and placement programs, loan payment programs, or widening vendor eligibility.

• Provide rehabilitation services for women who are substance abusers and provide substance abuse education.

• Expand the Women, Infants and Children (WIC) program to serve all eligible women and children.

• Implement the 1989 federal Budget Reconciliation Act provisions which require states to provide coverage for treatment to correct physical or mental health problems identified during EPSDT checkups.

• Improve implementation of the Family Life Education Curriculum in the schools to increase understanding of child development.

• Assist new parents in developing parenting skills, understanding child development, and accessing needed resources.

• Ensure that all children are properly immunized.

• Promote children's access to adequate nutrition.

• Increase availability of school-based clinics.

• Promote accident prevention.

• Promote the consistent use of child restraint devices and seat belts.

• Increase public awareness of defective or recalled infants' and children's products.

Population

Tennessee Population and Percent of Population under 18 Years, 1990

County	Total Population	Number Under 18	Percent Under 18
Anderson	68,250	16,334	23.9
Bedford	30,411	7,715	25.4
Benton	14,524	3,340	23.0
Bledsoe	9,669	2,368	24.5
Blount	85,969	19,662	22.9
Bradley	73,712	18,248	24.8
Campbell	35,079	9,003	25.7
Cannon	10,467	2,637	25.2
Carroll	27,514	6,531	23.7
Carter	51,505	11,389	22.1
Cheatham	27,140	7,606	28.0
Chester	12,819	3,014	23.5
Claiborne	26,137	6,668	25.5
Clay	7,238	1,674	23.1
Cocke	29,141	6,984	24.0
Coffee	40,339	10,379	25.7
Crockett	13,378	3,257	24.3
Cumberland	34,736	8,121	23.4
Davidson	510,784	116,541	22.8
Decatur	10,472	2,392	22.8
Dekalb	14,360	3,462	24.1
Dickson	35,061	9,576	27.3
Dyer	34,854	8,907	25.6
Fayette	25,559	7,641	29.9
Fentress	14,669	3,829	26.1
Franklin	34,725	8,530	24.6
Gibson	46,315	11,051	23.9
Giles	25,741	6,429	25.0
Grainger	17,095	4,171	24.4
Greene	55,853	12,797	22.9
Grundy	13,362	3,718	27.8
Hamblen	50,480	12,082	23.9
Hamilton	285,536	69,010	24.2
Hancock	6,739	1,701	25.2
Hardeman	23,377	6,621	28.3
Hardin	22,633	5,652	25.0
Hawkins	44,565	10,594	23.8
Haywood	19,437	5,638	29.0
Henderson	21,844	5,452	25.0
Henry	27,888	6,371	22.8
Hickman	16,754	4,019	24.0
Houston	7,018	1,691	24.1
Humphreys	15,795	3,971	25.1
Jackson	9,297	2,114	22.7
Jefferson	33,016	7,238	21.9
Johnson	13,766	3,191	23.2
Knox	335,749	75,112	22.4
Lake	7,129	1,565	22.0
Lauderdale	23,491	6,403	27.3
Lawrence	35,303	9,215	26.1
Lewis	9,247	2,479	26.8
Lincoln	28,157	6,980	24.8
Loudon	31,255	7,332	23.5
McMinn	42,383	10,374	24.5
McNairy	22,422	5,503	24.5
Macon	15,906	4,024	25.3
Madison	77,982	20,325	26.1
Marion	24,860	6,527	26.3
Marshall	21,539	5,454	25.3
Maury	54,812	14,278	26.0
Meigs	8,033	1,997	24.9
Monroe	30,541	7,731	25.3
Montgomery	100,498	26,633	26.5
Moore	4,721	1,203	25.5
Morgan	17,300	4,462	25.8
Obion	31,717	7,837	24.7
Overton	17,636	4,242	24.1
Perry	6,612	1,660	25.1
Pickett	4,548	1,117	24.6
Polk	13,643	3,294	24.1
Putnam	51,373	11,245	21.9
Rhea	24,344	6,158	25.3
Roane	47,227	11,107	23.5
Robertson	41,494	11,385	27.4
Rutherford	118,570	31,773	26.8
Scott	18,358	5,381	29.3
Sequatchie	8,863	2,286	25.8
Sevier	51,043	12,209	23.9
Shelby	826,330	226,307	27.4
Smith	14,143	3,539	25.0
Stewart	9,479	2,106	22.2
Sullivan	143,596	32,254	22.5
Sumner	103,281	28,448	27.5
Tipton	37,568	11,487	30.6
Trousdale	5,920	1,421	24.0
Unicoi	16,549	3,597	21.7
Union	13,694	3,669	26.8
Van Buren	4,846	1,273	26.3
Warren	32,992	8,294	25.1
Washington	92,315	20,085	21.8
Wayne	13,935	3,576	25.7
Weakley	31,972	7,037	22.0
White	20,090	4,804	23.9
Williamson	81,021	23,558	29.1
Wilson	67,675	18,539	27.4
Tennessee	**4,877,185**	**1,216,604**	**24.9**

Sources: The 1990 U.S. Census Population and Housing, Summary Tape File 1, Prepared by the Center for Business and Economic Research, The University of Tennessee, Knoxville, TN, 1991.

Sources

Page 2

1. Spending More and Getting Less: A Comparison of the Cost and Quality of Health Care in Tennessee, The United States and the World, (April, 1990). Tennessee Department of Health.

Page 4

1. Infant Mortality: Care for Our Children, Care for Our Future. (1988). National Commission to Prevent Infant Mortality.
2. Russell, K.P. Eastman's Motherhood. Seventh Edition. (1983). Boston: Little, Brown and Company.
3. Ibid.
4. Ibid.
5. Maternal and Child Health Branch, Division of Health Services, North Carolina Department of Health Resources. Healthy Pregnancy, Healthy Baby. (1983).
6. Tennessee's Health: Picture of the Present, Part Two, 1992.
7. Solutions to Issues of Concern to Knoxvillians. 1991. Focus on the Future: Improving Access to Prenatal Care for Low-Income Women. Presented at the Tennessee Black Health Care Commission Hearing in Knoxville, Tennessee, October, 1991.
8. Excerpt from the Tennessee Maternal and Child Health Block Grant Application for 1991-1992.

Page 5

Map and table: Tennessee's Health - Picture of the Present, Part Two, Health Planning Commission, 1992.

Page 8

1. National Center for Education in Maternal and Child Health. (1991). Infant Mortality Review. Washington, D.C.
2. Southern Regional Project on Infant Mortality. (1991). Investing In Prevention. Washington, D.C.
3. McCormick, M.C., Brooks-Gunn, J., Workman-Daniels, K., Turner, J., and Peckman, G.J. (1992). "The Health and Developmental Status of Very Low-Birth-Weight Children at School Age." Journal of the American Medical Association. Volume 267, Number 16.
4. Ibid.
5. Ibid.
6. Ibid.
7. Southern Regional Project on Infant Mortality. (1991). Investing in Prevention. Washington, D.C.
8. Ibid.
9. Ibid.
10. National Commission to Prevent Infant Mortality. (1988). Death Before Life: The Tragedy of Infant Mortality. Washington, D.C.
11. Ibid.

Page 9

Map and table: Tennessee's Health - Picture of the Present, Part Two. Health Planning Commission, 1992

Page 10

1. National Commission to Prevent Infant Mortality. (1988). Death Before Life: The Tragedy of Infant Mortality. Washington, D.C.
2. Ibid., Page 14.
3. Ibid.
4. National Center for Health Statistics. (1991). Infant Mortality. U.S. Department of Health and Human Services: Washington, D.C.
5. Brown, D. (June 4, 1992). The Washington Post.
6. Ibid.

Page 11

Map and table: Tennessee's Health - Picture of the Present, Part Two. Health Planning Commission, 1992.
1990 Census of Population and Housing, Summary Tape File 1, Profile 1. Prepared by the Center for Business and Economic Research, The University of Tennessee, Knoxville, 1991.

Page 12

1. Tennessee Medicaid Management Information System, Department of Health and Environment - Bureau of Medicaid, Reporting Period: October 1, 1990 - September 30, 1991.
2. Tennessee Department of Health. (1991). EPSDT Outreach Manual. Page 1-2.
3. Tennessee Medicaid Management Information System, Department of Health and Environment - Bureau of Medicaid, Reporting Period: October 1, 1990 - September 30, 1991.

Page 13

Map and Table: Tennessee Department of Health and Environment and 1990 Census of Population and Housing, Summary Tape File 1, Profile 1, Prepared by the Center for Business and Economic Research, The University of Tennessee, Knoxville. 1991.

Page 14

1. Growing Up Strong and Safe - A Personal Safety Curriculum from The Tennessee Department of Human Services. (1991). Page 2.

Page 15

Map and table: Tennessee's Health - Picture of the Present, Part Two. Health Planning Commission, 1992.
1990 Census of Population and Housing, Summary Tape File 1, Profile 1. Prepared by the Center for Business and Economic Research, The University of Tennessee, Knoxville, 1991.

Acknowledgments

Tennessee KIDS COUNT Director - Denise Dunbar, Ed.D
Tennessee KIDS COUNT Research Analyst - Jing Zhou
Writer/Editors - Denise Dunbar, Linda O'Neal, John Harding
Contributing Research Analyst - David Lewis
Editor - John Harding

Tennessee KIDS COUNT Technical Advisory Committee:

May W. Shayne, Chairperson
Research Associate, Vanderbilt Institute for Public Policy Studies

Gary Calfee
Director of Data Management,
Tennessee Department of Education

David Cordray
Professor of Public Policy,
Vanderbilt Institute for Public Policy Studies

Charles Glisson
Professor, College of Social Work,
University of Tennessee

Lorraine Greene
Deputy Director, "I Have a Future,"
Meharry Medical College

Robert Innes
Director of Undergraduate Studies in Human Development,
Vanderbilt University

William Robert Ives
Former Director of Research,
Tennessee Department of Finance and Administration

Robert Kronick
Professor of Education, College of Education,
University of Tennessee

Irving Lazar
Research Professor of Public Policy,
Vanderbilt Institute for Public Policy Studies

Lisa McInturff
Associate to the Planning Manager,
United Way of Middle Tennessee

Gregory Maynard
Director of Planning,
Tennessee Department of Youth Development

Matt Murray
Professor, Center for Business and Economic Research,
University of Tennessee

Joanne Jankovic Thompson
Assistant Professor, College of Social Work,
University of Tennessee

George Wade
Supervisor of Research and Development Unit,
Tennessee Department of Health

Robert Waters
Former Director of Planning and Evaluation,
Department of Mental Health and Mental Retardation

Charles Wilson
Director of Child Welfare Services,
Tennessee Department of Human Services

Tennessee KIDS COUNT Dissemination Advisory Committee:

Deborah Miller, Chairperson
Executive Director, Tennessee Board of Paroles

David Goetz
Executive Director,
Tennessee Business Roundtable

Adrienne Latham
Managing Editor,
The Metropolitan Times

Ann Marie Tugwell
Director of Community Relations,
Whittle Communications

Jim Word
Executive Vice-President for Public Affairs,
Tennessee Hospital Association

Frank Sutherland
Editor,
The Tennessean

Mike Kettenring
General Manager,
WSMV Television

Gordon Pafford
Supervisor, Agricultural Extension Service,
University of Tennessee.

Eddie Jones
Editor,
The Nashville Banner

Cal Bean
Program Director,
WPLN Radio

Linda Moynihan
Executive Director,
Tennessee Conference on Social Welfare

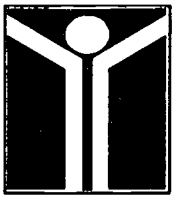
Special Thanks To:

Ron Simmons
Information Systems Technician,
Tennessee Department of Finance and Administration

George Plumlee
Statistical Analyst Supervisor,
Tennessee Department of Health

Ann Hogan
Statistical Analyst,
Tennessee Department of Health

Berdelle Campbell
Health Planner for Maternal and Child Health,
Tennessee Department of Health



Tennessee Commission on Children and Youth

Coordinators of Regional Councils on Children and Youth

Debbie Anderson
Northwest Council on Children and Youth
P.O. Box 505
112 West Maple
Dresden, TN 38225
(901) 364-5000

Cindy Perry
Mid-Cumberland Council on Children and Youth
404 James Robertson Parkway
Suite 1510
Nashville, TN 37243-0800
(615) 741-2633
FAX: (615) 741-5956

Kathy Daniels
Upper Cumberland Council on Children and Youth
1225 Burgess Falls Road
Cookeville, TN 38501
(615) 432-4111
FAX: (615) 432-6010

Julie Burnette
East Tennessee Council on Children and Youth
531 Henley Street #710
Knoxville, TN 37902
(615) 594-6658

Alma Carter
Northeast Council on Children and Youth
207 North Boone Street, Suite 800
Johnson City, TN 37604
(615) 928-0224
FAX: (615) 928-5209

Juanita White
Memphis/Shelby County Children and Youth Council
170 North Main, Room 707
Memphis, TN 38103
(901) 543-7657

Judy Renshaw
Southwest Council on Children and Youth
State Office Building, Box 13
Jackson, TN 38301
(901) 423-6545

Francis Elaine Williams
South Central Council on Children and Youth
P.O. Box 955
Spring Hill, TN 37174-0955
(615) 388-1053
Fax: (615) 381-2053

Marilyn Davis
Southeast Council on Children and Youth
540 McCallie Avenue, Suite 643
Chattanooga, TN 37402
(615) 634-6210

Central Office:
404 James Robertson Pkwy.
Suite 1510
Nashville, TN 37243-0800
(615) 741-2633
FAX: (615) 741-5956

Tennessee KIDS COUNT

Tennessee KIDS COUNT Director - Denise Dunbar, Ed.D
Tennessee KIDS COUNT Research Analyst - Jing Zhou
Publications Editor - John Harding

Tennessee KIDS COUNT is funded by The Annie E. Casey Foundation, whose KIDS COUNT grants are administered by The Center for the Study of Social Policy.

In Tennessee during 1990...

- 770 infants died before reaching their first birthdays
- Medicaid paid for 50 percent of all births
- 32.3 percent of all women who gave birth did not receive adequate prenatal care
- 6,160 babies weighed less than 5.5 pounds at birth
- 333 children ages 1 to 14 died
- More than one out of four children was eligible for Medicaid